**Minutes of the Health and Care Overview and Scrutiny Committee Meeting held on 13 December 2021**

Present: Jeremy Pert (Chairman)

**Attendance**

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| Charlotte Atkins | Barbara Hughes |
| Philip Atkins, OBE | Janet Johnson |
| Martyn Buttery | David Leytham |
| Richard Cox | Paul Northcott (Vice-Chairman (Overview)) |
| Ann Edgeller (Vice-Chairman (Scrutiny)) | Janice Silvester-Hall |
| Keith Flunder | Colin Wileman |
| Phil Hewitt | |

**Also in attendance:**
Lynn Millar – Director of Primary Care and Medicines Optimisation for 6 Staffordshire and Stoke -on -Trent, Clinical Commissioning Groups.
Simon Whitehouse, STP Director for Staffordshire and Stoke on Trent
Peter Axon, Interim CE ICS, Staffordshire and Stoke on Trent
Marcus Warnes, Senior Responsible Officer, Combined Staffordshire and Stoke on Trent CCG
Simon Evans, Chief Strategy Officer, The Royal Wolverhampton Hospital Trust
Paul Bytheway, Chief Operating Officer, UHMN
Duncan Bedford, Chief Operating Officer, UHDB
Mark Docherty, Executive Director of Nursing and Clinical Commissioning WMAS
Murray McGregor Communications Director, West Midlands Ambulance Service WMAS
Becky Scullion, Deputy Director of. Commissioning and Operations NSCCG
Sarah Jeffry, Head of Primary Care Development, NSCCG
Jennie Collier, Managing Director, Staffordshire & Stoke-on-Trent Care Group, MPFT
Steve Fawcett, Clinical Lead, Urgent and Emergency Care Transformation Programme
Tracey Shewan, Director of Communication and Corporate Services for 6 Staffordshire and Stoke on Trent CCGs
Richard Harling, Director Health and Care, SCC
Julia Jessel – Cabinet Member Health and Care, SCC
Johnny McMahon – Cabinet Support Member Public Health and Integrated Care, SCC

**PART ONE**

## 51. Apologies

Apologies were submitted on behalf of Councillors Rosemary Claymore, Jill Hood and Ian Wilkes.

## 52. Declarations of Interest

Councillor Ann Edgeller declared an interest as Partner Governor of the Midlands Partnership Foundation Trust (MPFT).

## 53. General Practice Access

The Director of Primary Care and Medicines Optimisation provided a detailed report and presentation relating to improving general practice access and the GP action plan, she also gave an update on expansion of the booster vaccination programme announced on 12 December 2021 and what that meant for general practice over the coming weeks.

Committee noted the main messages as follows:

- The activity in general practice over the last 4-5 months was compared data to 2019 levels, there had been a significant spike for demand on general practice.
- Staffordshire and Stoke on Trent area had demonstrated the most improved access to GP practices, 62% of appointments were face to face and work to improve access was having an impact.
- The majority of appointments were with GPs however practice nurses, advanced nurse practitioners and clinical pharmacists also had roles in practices seeing patients.
- 180 staff had been appointed to new roles in the primary care workforce to increase the range of service and support new ways of working in practices, such as social prescribers, first contact physio's and clinical pharmacists.
- Winter plans were robust, there were 4 programmes of work: (1) 3 respiratory hubs for paediatrics;(2) Additional capacity in primary care potentially creating up to 4000 additional appts per week; (3) Selfcare support – e.g., providing BP monitors for patients to use at home (4)111 been commissioned to provide additional support to free up general practice capacity.
- Levels of abuse, verbal and physical aggression against staff, in particular receptionist and customer first-line triage, was having an impact and causing some to leave. The Together Against Abuse Campaign had been launched and could be accessed through the 'Together We Are Better' website. It aimed to inform public and staff to be patient and to have zero tolerance against abuse at work. There would be continued offer of support and training for staff.

- 359,000 booster vaccines to be delivered by 31 December, the majority of vaccines were provided in primary care. CCG had stepped down a number of enhanced services to make capacity to deliver this, including the Quality and Outcomes Framework (QOF) and the improvement programme for PCNs. The vaccinations programme and emergency care were priorities which meant delays to other services including routine operations until after Christmas.
- Communications were in place and additional help from Councillors was welcomed to get the message out to communities relating to the need to deliver the vaccinations, the pressure of the booster programme and need to have patience with GPs.

There followed a period of questioning. In response to Members questions and comments the following was noted:

Quality and Performance

- A member had concerns that the Quality and Outcomes Framework (QOF) guidelines were suspended and asked whether safeguards were in place and of the longer term position from January onwards. CCG advised that Government had stepped down QOF until the end of March but that it had not been completely paused, monitoring of the most vulnerable patients and those at risk would be maintained. Further guidance from Government was awaited. It was explained that a bigger issue related to long term condition reviews, a full data review was being undertaken to ascertain impact on QOF outcomes over the pandemic. CCG gave assurance that mitigation was in place and that the review should be complete by April 2022.
- Variation in GP performance – All but 2 general practices in Staffordshire were rated as good or outstanding. A 360-degree review would be carried out for every practice in 2022 and quality reporting for every practice would commence after Christmas to ensure practices including community pharmacies were maximising the whole of the primary care workforce.

Vaccinations

- The number of vaccinations walk in centres had been increased to take the stress off general practices and a vaccination plan was in place. A list of locations would be circulated. SCC had provided additional support to vaccination sites and there were a range of stakeholders involved to provide different levels of access to maximise capacity. GPs were on board to deliver the booster jabs by 31 December.
- Vaccine supply was not a problem, however availability of work force to deliver the jabs was of concern, everyone was committed to deliver them to prevent a Covid peak after Christmas.
- 6 million people were not immunised in the UK, there was an absolute understanding of numbers that need to be vaccinated in Staffordshire, 359,000 plus a number of people who need first or second jab. The

numbers would be shared and passed on with Local Outbreak Control (LOC).

Access to GP Surgeries.

- The strategy for the model of care would contain detail about the way people access services moving forward.
- Currently 400,000 primary care appointments per month, the increased demand had led to additional surgeries per week to provide more access. There was the same level of capacity in practices but rising demand due to people catching up on prescriptions, meds reviews and matters delayed during lockdown. The data highlighted that the increase in demand started in April 2021, peaked in June, and had started to come down in October.
- To respond to 100,000 additional phone calls per a week CCG had deployed additional solutions. There were reports that people were waiting a long time on the phones and frustrations had been taken out on staff, verbally and physically, as a result some reception staff had left. The abuse was widespread across all practices and a plan was in place to address violence or aggression from public, including additional security, CCTV security alarms and panic buttons. There was a zero-tolerance policy in place and the Committee was very clear that it did not condone any violence or abuse against staff.
- CCG meet with all 146 practices annually and were working with the lower percentile 2%. Some practices were resistant to change. Practice contracts had been removed in the past working closely with CQC, but there must be specific reasons on quality and safety grounds - poor access was not a reason to remove a contract.

The Committee considered the 7 action areas in the Primary Care Action Plan in further detail and the following responses to questions were noted:

Communications

- Digital working and telephony improvements were being addressed and supported. It was suggested that online information should include how best to access the variety of services, the link into the NHS app and appointment booking and links to the most appropriate person to help them.
- A blend of remote and face to face access must be available. Each practice had a different operating model and software being used, there was a need to standardise and link them up. The majority of practices used EMIS, patient information was recorded on an integrated care record, joining up the NHS system. A system called accuBook was also used and could enable sharing when patient information was clinically required.
- There was concern that some patients have difficulty with digital. The access plan included tailoring contact with the individual with a range of access mechanisms and part of the training for receptionists was to

recognise patient needs. Practices that were not performing were being supported.

- The standard offer - The Primary Care Strategy aims to develop universality and a consistent offer for patients and work to engage on the strategy which starts in the new year. The universal offer would be 15 service lines offered consistently across practices in Staffordshire.
- Members highlighted Patient Participation Groups PPG as a good way to communicate with patients about issues. CCG advised most practices have one, but it is not a requirement under their contract.
- It was clarified that there were 20 Physician Associate positions out of 600 GPs in Staffordshire. Numbers and location of other professional roles would be provided for information and confirmation was given that primary care level appointments were shared roles across practices.

Access improvement programme.

- Targets and objectives gave focus and direction to make the improvements, CCG had learned lessons from the use of data in vaccine programme to drive improvement and would use data to drive improvement in the programme for GP practices.
- CCG advised that a data validation process was underway to ensure data was consistent, open, and transparent and shared between practices and the public. Members highlighted the need for GP practices to recognise the need to share information to improve services. CCG confirmed there was a team of data quality assessors who have permission from GPs to work across all 146 practices to look at QOF indicators and other data.
- CCG were working closely with practices with greatest access challenges. Practices were also sharing and adopting best practice with each other and tailoring it to their practice.
- The whole of NHS was facing workforce shortages and a challenge was to make sure staff were not moved around too much, this was also the case for community pharmacists and mental health MPFT practitioners. The ICS would be commissioning community pharmacists to deal with specific conditions from April 2022, this was currently commissioned by NHS England.
- Concern was raised that only 14 practices were engaged in the access improvement programme. CCG advised that when the 'Time for Care' programme commenced in September 2021 practices reacted well, but the unprecedented level of demand, pressures and additional workload had caused it to pause; practices would pick it up when there was capacity.
- A member questioned how unmet demand or unmet need would be identified, particularly from those most vulnerable and those who have difficulty accessing the system. CCG advised that this would be attained from the data, each practice had a register and should through mapping data be able to identify where there were usually

high level of deprivation or hotspots, to ascertain where lower than expected levels of demand were.

Digital

- Committee welcomed digital access to appointments and the range of services, some of which had already been discussed under communications action. The concern was that some patients could not access or use digital services and wanted to see a GP because they did not know the alternatives. CCG acknowledged that when services changed to the new model, more could have been done to introduce the new practice team and how they could help people but that that this was being addressed and videos were now on social media, youtube and facebook to give advice on the range of alternatives.
- It was recognised that many people had phones and were able to use them, for those that did not, there were leaflets and communications could be tailored to meet individual need.
- It was confirmed that most practices had a facebook page and could share information and videos, but it was acknowledged that there was still more to do on communications.

Quality variation and resilience

- CCG was monitoring indicators closely and recognised that access was a sign of quality.
- It was not possible to identify and deal with all issues impacting on quality in the same way because each practice had different issues affecting it. The approach was to consider individual practice by practice issues and to use the data effectively to prioritise those of most importance.
- A member requested that members be advised of feedback from the health inequalities survey and an update considered at a future meeting.
- CCG advised that the review of the consultation dashboard had taken place and the national plan around winter access had taken findings into account. Members were advised that 61 indicators were monitored on a practice by practice basis, these were not in the public domain, however GPs did share between themselves and challenge their peers practice level data.

Training and development of staff

- The 2016 Government announcement of 5000 more trained and recruited GPs by 2021 had not been realised and there were now 1300 less than in 2016. In Staffordshire there were 100 fewer GPs than in 2016. The primary care strategy to address the shortage of GPs had been to optimise the practice footprint. 172 practices had been reduced to 146 with an increased patient base. Practices were getting bigger and moving away from single handed practices to ensure they were resilient.
- Concern was raised about population growth in some areas and the planning policy not to contact CCG unless more than 500 houses were being built. CCG advised that planning officers had recently been

appointed to take a helicopter view of the area and to work with developers to consider health sites. It was confirmed that there was no demand for new health buildings but that it would be important to work with the planning system to optimise the practice footprint, for the practice to be more resilient and to manage a multi-disciplinary team amongst the practices on one site.

- It was confirmed that all 175 spaces on the first staff training course relating to conflict and de-escalation for practice staff had been taken and additional courses were planned for the new year. There was a positive response about the training from all GP practices.
- A member questioned how we would know if patients were being offered the most appropriate appointment for them. There was no formal mechanism for monitoring appropriateness of the appointment but there was a range of data to work through, such as the patient survey, satisfaction rates at the surgery and soft intelligence. CCG welcomed the question and agreed to take it into consideration. It was also thought to be a useful indicator for the practice 360-degree review work.

The Chairman thanked presenters for a clear presentation and welcomed the data and detail in the report. He summarised that the Committee supported zero tolerance of abuse on staff, appreciated the work being done to progress the action plan and the approach to let data drive and focus on the actions. He welcomed that the future plan and work on performance indicators was progressing and indicated that that the committee would continue to monitor progress. Also, that the Committee had highlighted a need to consider whether the estate was fit for purpose and had asked for the vaccine plan and Primary Care Strategy to be shared when ready. The Chairman thanked partners for all the work they were doing.

**Resolved:**

1. That the general practice access update report and presentation be noted.
2. That CCG share the Vaccine Plan, Primary Care Strategy and feedback from the Health Inequalities Survey with the Health and Care Overview and Scrutiny Committee when they were ready to share.
3. That a further update on General Practice Access be included on the Health and Care Overview and Scrutiny Committee work programme in 6 months.
4. That an item be added to the work programme for 2022-23 relating to NHS estate.

## 54. Urgent and Emergency Care for Staffordshire and Stoke-on-Trent

The Director Staffordshire and Stoke on Trent STP introduced the item and advised that partners from Integrated Care System (ICS), Clinical Commissioning Group (CCG), West Midlands Ambulance Service (WMAS), University Hospitals Midlands North (UHMN), University Hospitals Derby and Burton (UHDB) and Royal Wolverhampton Trust (RWT) were in attendance to provide detail and context to the paper and to respond to questions relating to the current pressures across the system.

The STP Director gave thanks and recognition to the amazing work that front line and support staff in all setting from across the system were providing at present, had continued to provide through the pandemic, and were now being asked to provide again to deliver the vaccination booster programme by 31 December 2021. He welcomed that Partners were working together to get the system right for residents across Staffordshire recognising the pressures on all levels.

The STP Director advised the public that the NHS remained open, and that people should come forward and get the care they need. He gave assurance that NHS and Partners were working hard to address the system pressures and apologised for any delay or inconvenience the public were experiencing which may be leaving people in pain and discomfort while waiting for procedures and tests. He presented the partnership response to the current pressures across the system and explained that the report set out to move away from organisational boundaries and looked in detail at three key stages: pre-hospital, in hospital and discharge.

The Chairman thanked the STP Director for the presentation and congratulated him on his recent appointment to Chief Executive of the Shropshire, Telford and Wrekin Integrated Care System (ICS). He thanked him for all the work he had done in Staffordshire over recent years and for bringing colleagues together around the table at this meeting.

Committee noted the following comments and responses to questions:

Pre-hospital:

- A member indicated that people had a personal responsible to look after themselves and also suggested that hazard analysis critical control points could be looked at, such as gritting the streets when icy to avoid accidents occurring.
- WMAS highlighted calls for ambulance and handover delays.
    - delays to handover patients at hospitals was a problem. At Royal Stoke Hospital 16% of time was lost compared to any other hospital in the area. The hospital was surrounded by rurality and there was

no other hospital close for ambulances to go to, particularly out of hours when Stafford A&E site was closed. It was confirmed that WMAS were not suggesting Stafford be open at night and that was not the message to take from this.
    - high number of calls were made for ambulance service was a concern, particularly when there was nowhere else to phone or get advice from in the middle of the night. People could be encouraged to try other services before requesting an ambulance, such as a call to 111 for advice. There was also positivity about the effectiveness of the Community Rapid Intervention Scheme (CRIS) in North Staffordshire reducing 2/3rds of calls entering hospital.
    - The closure of the community ambulance sites in North Staffordshire had been a difficult decision but had freed up 12 hrs of ambulance time on the road per day.
- Acute Trusts challenge handover delay
    - UHMN – highlighted the challenges that the system was facing, workforce issues, the hospital was operating at 97-98% occupancy and was looking at ways to reduce that. They were trying to support and work with WMAS to reduce waiting times and get ambulances back out on the road.
    - UHDB – Flow was critical and could have a problem at any point, pre-hospital, in hospital or discharge, all could be critical if any point started to fail the system would struggle.
    - RWT – workforce was the main challenge, ongoing issues and inability to recruit staff to all levels meant that they could not get the system working as they would like. Issues faced at the front of the hospital were probably due to what is happening at the other end of the system, there were wards with medically fit for discharge patients that could not be released to the right place for them, safely.
- Emergency Calls - Councillors and Councils could have a role to make public aware of the alternatives. Public may instinctively want a GP or dial 999, it was considered that people need information to tell them where to go and how best to help themselves in an emergency.
- The impact of conveyancing and waiting times on individuals was questioned. WMAS advised that behind the data and numbers were individuals in individual circumstances. It was explained that there were different category calls: Category 1 –was a priority and the patient may be critical, a response time of 8 min 46 sec was averaged and 90% were reached under 15 minutes; Category 3, may be a frail elderly person who had fallen, but wait for up to 9 hours. At this point after 9 hours the patient may have other problems, pressure problems cold etc. The system challenge was to move people through the system as efficiently as possible to reduce the waiting times at the front end when waiting for an ambulance.

- It was explained that emergency ambulances do not transport patients for appointments and that patient transport ambulance are in a different category.
- 111 service was available to advise and help people navigate through the complex health system. Councillors agreed the need to promote 111, support and promote community resilience and infra structure and to mobilise the voluntary and community sector to support and work alongside the services.
- Members questioned how many patients were conveyanced into acute hospital that should not be**:**
    - WMAS response was the numbers were not large. It was explained that paramedics had to cover a wide range of illnesses, they have to make the decision whether to take people in or leave them at home, they had to be risk averse but not so much that they take everyone in. Conveyance level was at 37%.
    - UHMN Acute –WMAS take people to Royal Stoke because there was no other place to take them overnight. Work was to be done on alternative providers and engaging with WMAS to have conversation with CRIS to reduce conveyance to Royal Stoke. The winter plan work included accessing community services from the ambulance and from the front door and looking at patient transfer to Vocare directly rather than through the Royal Stoke process.
    - Community hospital services and the CRIS service supporting people to stay at home, working on preventative pathway frailty and falls to reduce the number of people being conveyed to hospital. They were also looking at services as an alternative to emergency department, such as the walk-in centre at Haywood and the minor injury unit.
    - WMAS advised that delays could not be avoided, however the advice to people in a category 3 call had been changed to take account that excess delay could cause complications, patients were now advised to eat, drink, keep warm and if they could be moved safely then do.
    - The need to mobilise all available resources and to get neighbourhoods and communities involved to help, look after elderly and vulnerable neighbours was highlighted.
- Members questioned how many 999 calls were essential and how could demand of walk-ins at A&E be reduced
    - An important message to the public was that there is no blame or being apportioned if a member of public needed the service, they should not delay contacting NHS services. If there was a genuine emergency the public needed to know how to get the right support.
    - 999 calls and ambulances needed to be for the right people at the right time. The 111 service was a gateway to talk to a clinician about their issue and to find the right service for them. This could be online, phone, 111 app or to access a 111 kiosk at an

emergency centre. The 111 service had extended to meet need so that people can be seen nearer to home, in a pharmacy or in their community if they do not need to go to A&E.

In hospital:

- The ICS is not involved in any discussions about Nightingale hospitals in Staffordshire. The travel time for Staffordshire & Stoke on Trent residents to Manchester or Birmingham ruled it out and conversations with hospitals determined that demand would be managed locally.
- When do partners anticipate seeing the impact and change as a result of the initiatives?
    - The challenge for acute hospital trusts with recruitment was a national issue, for nursing vacancies everyone was searching in the same pool and there was no benefit in people moving from one provider to another. UHMN was also looking for consultants through targeted recruitment. There would be extra staff needed to come out of recovery following winter pressures.
    - An immediate pressure was staff sickness, the staff group were suffering from fatigue, they had worked on adrenaline and goodwill which was incredibly tiring.
    - Other issues highlighted were the difficulty to recruit when dealing with level of aggression from the public and other organisations paying more for home care workers and other roles.
    - The recruitment of home care workers and of registered nurses was an issue for community nursing, the demand for therapy, increased level of deconditioning and supporting people post Covid.
- In terms of mental health and wellbeing offer for staff, hospitals had a good system wide offer and individual uptake had been good, there was capacity for people reaching out to use the support available. At UHMN there had been bespoke programmes for critical care staff the impact of high number of deaths had been significant. In the Community the backlog of work had impacted on staff enthusiasm, and some did not feel they were able to deliver their best at the moment.
- A Member welcomed that partners had recognised the issues and were looking to fix the system. He voiced admiration for them, and the way system partners were working together to maximise capacity and consider the alternatives to address the pressures and deliver the services. The STP Director appreciated the comments made and asked that provider colleagues pass this recognition back to their organisations and staff on and in support of the frontline.

Discharge

- Committee was given assurance that there was sufficient winter surge bed capacity:
    - Community hospital had temporarily opened additional beds at Cheadle hospital which had opened up more capacity at Haywood Hospital over winter. Discharge to Assess (D2A) home care beds had commissioned more capacity as rehabilitation facility at care homes up and down the County, and framework in place with 27

beds in care homes plus; additional beds could be purchased on a patient by patient basis. There was also Home First surge capacity however the challenge was that these were taken up due to lack of domiciliary care in the community.

- Acute hospitals: there were 3 winter wards at Stoke hospital and 1 ward at County hospital; Pressure wards at RWT were open and at UHDB winter wards were open and hoping to open some more community hospitals beds to relieve the pressures.

The Chair thanked STP Director for a clear and concise report and summarised main messages.

- The benefits of CRIS in the North Staffordshire area and the opportunity to roll CRIS out further.
- Opportunity to look at different landscape it would be helpful to see the system wide action plan that sits behind today's discussion.
- Committee recognise the issues and that partners system wide were working together and want to solve the problem and not lay blame at any one organisation
- The call to work together for all residents of Staffordshire.

The Chairman thanked all partners for their ongoing contribution and for everything they were doing.

**Resolved:**

1. That the update report be received and noted.
2. That the System Wide Action Plan be shared with the members

## 55. Home Care Update

The Health and Care Cabinet Member introduced the report. She indicated that system pressures and recruitment of staff were an issue in home care which had already been referred to in the meeting today. She highlighted that there was also a 20% increase in demand for home care services and a backlog of assessments for homecare which was having impact on the individuals, on discharge from hospital, home first service and beyond. She advised that work was ongoing to look at the issues and that more strategic work was being done with regards to recruitment and retention to secure more home care staffs in the immediate, medium, and long term.

The Director of Health and Care advised that the twin pressures of rising demand for home care and challenges with the workforce were national problems. The 20% increase in demand since July had created pressure in terms of supply workforce and it was getting more difficult to recruit staff to address the backlog and to increase homecare supply. He confirmed that Staffordshire County Council (SCC) was working closely

with NHS colleagues to address issues and that it had received £2.8 million from NHS which would go out to care providers to fund loyalty schemes over the winter period. There was also an additional £162m government fund for home care, of which SCC share was £2.5m.

The following comments and responses to members questions were noted:

Outline of development of career pathways

- The mitigations in the paper were short term, in the medium and longer term the intention was to encourage people into the care sector following a career path. Start in a care role, develop skills and training opportunities; potentially link with an NHS role and develop more knowledge and skills training. The object was to attract new people into the sector.
- The development of the pathway was in early stages and possibly 6-9 months away from piloting with a few hundred staff members. The proposal was to develop different pathways to trial and evaluate to develop over time.
- Health and Care work closely with the NHS, recognising that both had a role in the joint care of vulnerable people, there was recognition of need to work closely and potentially develop joint care career paths.
- The Council would continue to plan for the future, working and supporting various providers but also trying new things, providing the best services with the resources we have.
- To make a career in care the report refers to grants for training. The further education offer had changed recently, grants and training loans were available for people of any age. The County Council would take the lead on the career pathway, and an outline project plan had been drafted and considered by Cabinet to develop a career path linked to relevant qualifications. There would be a period working with partners and providers and a period of finding out what would attract people to a career pathway which would be part of the project plan. The Cabinet Member for Health and Care would work with the Cabinet Member for Skills and Economy to create a career pathway that attracts people into the profession and work together to raise the profile and the status of care workers.
- The Chairman suggested Members who had governor roles on schools and colleges raise the opportunity for a career in the care profession with educational professionals.

How many packages of care were handed back?

- Ordinarily numbers were low, this may be where there were issues between the provider and the individual and they did not want to continue the arrangement. If home care providers fail, care packages

were handed back, the packages were transferred to other providers.

Maximising capacity

- about 46,000 care hours were currently being commissioned and we need to use these to best effect through flexible call times. If call times are very specific, they were difficult to resource, providers have more flexibility where they indicate morning afternoon and night. Where possible people's preferences were accommodated.
- New capacity was about recruiting new staff and creating additional hours. An additional service was being created in North Staffordshire and Stoke on Trent and provided by Stoke on Trent City Council outreaching into Staffordshire. Recruiting additional staff would create additional capacity alleviates pressures and backlog on home first and gets people out of hospital. The critical constraint was the supply of staff and Stoke on Trent CC were trying to recruit at this time. The aim was for people to move into the homecare sector.

Different pay rates

- The Council has two standard rates for home care staff, one standard and one to reflect rural aspects. 93 % were commissioned on these two rates, in addition some non-contracted providers 7% were used. The risk of underdeveloped safeguarding process with non-contracted providers was mitigated by keeping contact with them, have regular conversations, the normal QA processes do not apply because they are out of contract.
- There was a difference in pay between NHS homecare providers and the 2 Local Authorities and incentives to encourage carers not to move from one service to the other. More new people were needed in care roles.

**Resolved:**

1. That the update report be received and noted the actions being implemented to support the sector and increase capacity, especially over the Winter period

The Chair thanked all officers and partners for their attendance and contributions at the meeting today. He welcomed the seniority of witnesses and expertise in the room, the strong partnership approach to consider system pressures and how the three conversations in the meeting today were interlinked and clearly highlighted the knock-on effects of pressures in the system as we move into the Winter period.

The Chair thanked committee for their endeavours over the past twelve months and wished them a good Christmas break with family and friends and to come back refreshed for the work that lay ahead.

**Chairman**